PUBLIC HEALTH, WELFARE & SAFETY
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Testimony on SB 95

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Cardiovascular disease, including heart disease and stroke, is the leading cause of death in Montana and in the United States. In 2004, there were 1,791 deaths (five deaths per day) among Montana residents from heart disease, and 516 (29%) of these deaths (ten deaths per week) from sudden cardiac arrest occurred out-of-the hospital. The median rate of survival to hospital discharge for witnessed sudden cardiac arrest is 6% in the United States. As Senator Smith indicated, some of these deaths could be prevented by quickly identifying persons experiencing sudden cardiac arrest, activating the Emergency Medical Services system by calling 911, providing CPR and using an automated external defibrillator (AED), providing advanced cardiac life support services, and transporting to the appropriate acute care setting where additional treatment can be performed.

Let me elaborate on the use on an AED. Many persons experiencing sudden cardiac arrest have an abnormal heart rhythm called ventricular fibrillation, which causes the heart to quiver so it does not pump blood effectively. Over 40% of persons experiencing sudden cardiac arrest have ventricular fibrillation. Treating ventricular fibrillation requires the delivery of a shock to the heart, which allows the victim's heart to resume a normal rhythm. This is what an AED does.

AEDs are highly accurate, user friendly computerized devices with voice and audio prompts that guide the user through the life saving steps. They are designed for lay users and first responders to reduce the time to defibrillation, which is a key to improving the likelihood of

survival for the victim. The rescuer turns on the AED and attaches adhesive electrodes to the victim. The AED records the victim's cardiac rhythm and prompts the rescuer to deliver a shock, if the victim is experiencing ventricular fibrillation. Public AED programs, that include EMS activation and CPR, have been shown to reduce the time to defibrillation for persons experiencing sudden cardiac arrest, and to improve survival rates. In Montana numerous pubic AED programs have been established. The Department has also utilized Federal grant funding to purchase and distribute AEDs to targeted public locations throughout the state, including EMS and law enforcement services, government buildings, and Community Health Centers. These sites were targeted because the likelihood of witnessed sudden cardiac events happening in these locations is high, and the frequency of high-risk persons at these locations.

To establish an AED program in Montana currently, four criteria need to be met:

a) planning and oversight of a community lay program by physician;

b) training in CPR and AED use for anticipated rescuers;

c) linkages with the local EMS system; and

d) regular AED maintenance and readiness-tests for AEDs and program staff

There are a number of potential barriers to establishing public AED programs in Montana. One is the potential liability for persons who oversee these programs, rescuers, and the facilities where these programs are located. The State of Montana has addressed this issue by providing "good Samaritan" limited immunity for these individuals and facilities. A second potential barrier relates to persons eligible to provide oversight for these programs. The current Montana law indicates that only a physician or an individual designated by a physician can oversee an AED program.

In 2005, the American Heart Association published revised national guidelines for public AED programs that changed the recommendations for program oversight. The American Heart Association now recommends that oversight for an AED program can be performed by a health care professional with training and expertise in areas such as emergency care and cardiovascular care. These professionals include not only physicians, but also mid-level practitioners, nurses, and paramedics. The American Heart Association recognized that while it is good to have physician oversight for these programs, it is not necessary to have that level of expertise. Additionally, obtaining physician oversight for these programs may not always be feasible. Removing this barrier from our State law will allow the continued establishment of these critical programs here in Montana. The changes in the statute included in SB 95 would accomplish this goal.

Thank you for considering this bill. On behalf of the Department I would like to thank Senator Smith for sponsoring this important legislation.